HEALTHCARE ANALYTICS SUMMIT 15
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Session 13: Lessons Learned

How a Pioneer ACO is Using Analytics to Improve the Management of Heart Failure

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1. **Start small and work your way up.**

   A clear focus on specifically defined improvement goals at an achievable scale is very important at the start. It is best to start small, learn from experience, and disseminate best practice as the desired outcomes are achieved. Avoid the tendency to "do anything" in favor of doing something that will demonstrate early success.

2. **Reaching out to people reaps enormous benefits.**

   Organizations do not achieve outcomes, people do. Leaders must be adept at building relationships—one person at a time. Good leaders understand that the organization is a community of relationships. This approach yields enormous benefits. When meeting people, a key opening phrase is "I am reaching out to you…"

3. **A strong, motivated physician champion/leader that has the time to spend on leading and driving things forward is essential.**

   Healthcare improvement teams benefit from having a physician champion. The physician champion helps make the case for other physicians to support an improvement idea. They also help assure outcomes that work, that benefit patients, and that are sustainable over time. Despite the naysayers and skeptics, physicians can serve as a cheerleader to keep motivation and enthusiasm at the levels needed for success!

4. **Care Coordinators and the NPs play a vital role in making the HF program work.**

   People with chronic conditions are at high risk of poor care coordination, leading to test duplications, medical errors, and adverse health outcomes. Easy access and communication with health care providers including nurse practitioners, a care coordinator, and a positive patient-provider relationship is an effective strategy for improving outcomes among patients with complex health care needs. HF patients are complex—they need a clinician with clinical expertise to make the right things happen at the right time.

5. **Everyone on the care team needs to step up and look for care gaps (ways to improve care).**

   In the care of chronic disease populations, it is often true that no one entity or provider is responsible for managing the care process across the continuum of care. A key strategy to improve care is to encourage all involved in the care of patients with chronic diseases to look beyond their individual roles to identify gaps in care and determine how to improve overall care coordination. No single leader knows it all—they really need people "on the ground" to contribute their ideas and suggestions on how to improve the process!

Choose at least one thing that you've learned today that you will share or do differently as a result of listening to this presentation. Write this down below and the date to accomplish it.

Goal(s) or Learning(s) **Date**